medical resources located in another state.

(3) To receive payments, the out-of-state provider must enroll in the Montana medicaid program. Enrollment information and instructions may be obtained from the department's fiscal intermediary, ACS, at P.O. Box 4286, Helena, MT 59604-4286.

(4) The department will reimburse a nursing facility located outside the state of Montana under the Montana medicaid program only if, in addition to meeting other applicable requirements, the facility has submitted to the department the following information:

(a) a physician's order identifying the Montana resident and specifically describing the purpose, cause and expected duration of the stay;

(b) for nursing facility services, copies of documents from the facility's state medicaid agency establishing or stating the facility's medicaid per diem rate for the period the services were provided;

(c) for separately billable items, copies of documents from the facility's state medicaid agency establishing or stating the medicaid reimbursement payable for such items for the period the items were provided;

(d) a properly completed level I screening form for the resident, as required by ARM 37.40.201, et seq.;

(i) To the extent required by ARM 37.40.201, et seq., a level I screening must be performed prior to entry into the nursing facility to determine if there is a diagnosis of mental illness or mental retardation and if so, to conduct assessments which determine the resident's need for active treatment. A level I screening form may be obtained from the department.

(e) a copy of the preadmission-screening determination for the resident completed by the department or its designee;

(i) Payment will be made for services no earlier than the date of referral for screening or the date of screening, whichever is earlier.

(f) the resident's full name, medicaid ID number and dates of service;

(g) a copy of the certification notice from the facility's state survey agency showing certification for medicaid during the period services were provided; and

(h) assurances that, during the period the billed services

37.40.345 ALLOWABLE COSTS (1) This rule applies for purposes of determining allowable costs for cost reporting periods beginning on or after July 1, 1991. Allowable costs for cost reporting periods beginning prior to July 1, 1991 will be determined in accordance with rules for allowable costs then in effect.

(2) For purposes of reporting and determining allowable costs, the department hereby adopts and incorporates herein by reference the Provider Reimbursement Manual (PRM-15), published by the United States department of health and human services, social security administration, which provides guidelines and policies to implement medicare regulations and principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended. A copy of the PRM-15 may be obtained through the Department of Public Health and Human Services, Senior and Long Term Care Division, P.O. Box 4210, 111 Sanders, Helena, MT 59604-4210. Applicability of the PRM-15 is subject to the exceptions and limitations specified in this rule.

(a) The term "allowable costs" means costs which are allowable under the provisions of this subchapter and which are considered in determining the costs of providing medicaid nursing facility services. The determination that a cost is an allowable cost does not require the department to reimburse the provider for that cost. Providers will be reimbursed only as specifically provided in these rules.

(3) For purposes of reporting costs as required in ARM 37.40.346, allowable costs will be determined in accordance with the PRM-15, subject to the exceptions and limitations provided in these rules, including but not limited to the following:

(a) Return on net invested equity is an allowable cost only for providers of intermediate care facility services for the mentally retarded which provide services on a for-profit basis.

(b) Allowable property costs are limited as follows:

(i) The capitalized costs of movable equipment are not allowable in excess of the fair market value of the asset at the time of acquisition.

(ii) Property-related interest, whether actual interest or imputed interest for capitalized leases, is not allowable in excess of the interest rates available to commercial borrowers

from established lending institutions at the date of asset acquisition or at the inception of the lease.

(iii) Leases must be capitalized according to generally accepted accounting principles.

(iv) Depreciation of real property and movable equipment must be in accordance with American hospital association guidelines. Depreciation of real property and movable equipment based upon accelerated cost recovery guidelines is not an allowable cost.

(v) In accordance with sections 1861(v)(1)(O) and 1902(a)(13) of the Social Security Act, allowable property costs shall not be increased on the basis of a change in ownership which takes place on or after July 18, 1984. Section 1861(v)(1)(O) and section 1902(a)(13) of the Social Security Act are hereby adopted and incorporated herein by reference. The cited statutes are federal statutes governing allowability of certain facility property costs for purposes of medicare and medicaid program reimbursement. Copies of these sections may be obtained through the Department of Public Health and Human Services, Senior and Long Term Care Division, P.O. Box 4210, 111 N. Sanders, Helena, MT 59604-4210.

(c) Administrator compensation is allowable only as determined according to the PRM-15 provisions relating to owner compensation, and as specifically limited in this rule.

(i) For purposes of reporting and determining allowable administrator compensation, administrator compensation includes:

(A) all salary paid to the administrator for managerial, administrative, professional or other services;

(B) all employee benefits except employer contributions required by state or federal law for FICA, workers' compensation insurance (WCI), federal unemployment insurance (FUI), and state unemployment insurance (SUI);

(C) all deferred compensation either accrued or paid;

(D) the value of all supplies, services, special merchandise, and other valuable items paid or provided for the personal use or benefit of the administrator;

(E) wages of any provider employee to the extent such employee works in the home of the administrator;

(F) the value of use of an automobile owned by the provider business to the extent used by the administrator for uses not related to patient care;

other than the resident's patient contribution and any items billable to residents under ARM 37.40.331.

(3) This rule applies in addition to ARM 37.85.415. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00.)

37.40.352 UTILIZATION REVIEW AND QUALITY OF CARE

(1) Upon admission and as frequently thereafter as the department may deem necessary, the department or its agents, in accordance with 42 CFR 456 subpart F (1997), may evaluate the necessity of nursing facility care for each medicaid resident in an intermediate care facility for the mentally retarded. 42 CFR 456 subpart F contains federal regulations which specify utilization review criteria for intermediate care facilities. The department hereby adopts and incorporates herein by reference 42 CFR 456 (1997). A copy of these regulations may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-142, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489.)

Rules 53 through 59 reserved

37.40.360 LIEN AND ESTATE RECOVERY FUNDS FOR ONE-TIME EXPENDITURES (REPEALED) (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2001 MAR p. 1108, Eff. 6/22/01; REP, 2003 MAR p. 1294, Eff. 7/1/03.)

37.40.361 DIRECT CARE WAGE REPORTING (1) Effective for the period July 1, 2001 and thereafter, nursing facilities must report to the department entry level and average hourly wage and benefit rates paid for direct care workers. The reported data shall be used by the department for the purpose of comparing rates of pay for comparable services. There will be no separate per day add-on computed for direct care wages after June 30, 2001. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02.)

37.5.310 ADMINISTRATIVE REVIEW AND FAIR HEARING PROCESS FOR MEDICAL ASSISTANCE PROVIDERS (1) The following administrative review and fair hearing process applies to all medical assistance providers that are aggrieved by an adverse action of the department, except medical assistance providers appealing eligibility determinations as a real party in interest.

(2) A medical assistance provider, other than a medical assistance provider appealing an eligibility determination as a real party in interest, aggrieved by an adverse action of the department may request an administrative review. The request must be in writing, must state in detail the provider's objections, and must include any substantiating documents and information which the provider wishes the department to consider in the administrative review. The request must be mailed or delivered to the Department of Public Health and Human Services, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210 and should be addressed or directed to the division of the department that issued the contested determination. The request for administrative review must be received by the department within 30 days of mailing of the department's written determination.

(a) Within the 30 days a provider may request in writing an extension of up to 15 days for submission of a request for administrative review. The department may grant further extensions for good cause shown. Requests for further extensions must be in writing, must be received by the department within the